June 2015

Montana Central Tumor Registry Newsletter

Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

MCTR Receives Two Awards of Excellence

The Montana Central Tumor Registry has recently received awards from the Centers for Disease Control and Prevention (CDC) and the North American Association of Central Cancer Registries (NAACCR) for excellence in timeliness of reported data, completeness of case ascertainment, and quality of data that's collected.

The CDC recognizes Montana as a Registry of Excellence. This achievement indicates that the MCTR has met all CDC National Program of Cancer Registry (NPCR) Standards for Data Completeness and Quality. Of 48 state cancer registries supported by the CDC, Montana is one of 19 registries who achieved this designation for the most recent data submission. Montana's data is included in this year's publication of *United States Cancer Statistics* (USCS) and other analytic data sets. You can use the USCS data at http://nccd.cdc.gov/USCS/.

The NAACCR recognizes Montana with Gold Certification. This certification recognizes that Montana collects timely, complete, and quality data. Montana's data is included in this year's publication of *Cancer in North America (CINA): 2008-2012* for the U.S. incidence, Montana incidence, and U.S. mortality. You can use the CINA data at http://www.naaccr.org/DataandPublications/CINAPubs.aspx.

These accomplishments would not be possible without the timely and complete reporting from all Montana hospitals, physicians, and pathologic laboratories. We complement and thank you for your hard work! You deserve this recognition as much as the MCTR does.

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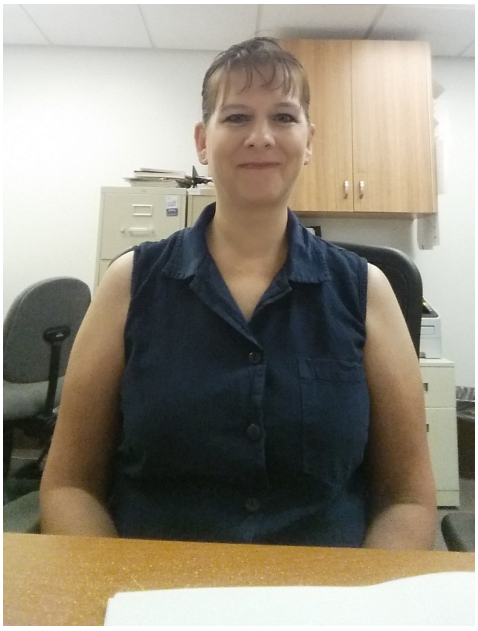
Meet the Registrar



Vicki Smith, Cancer Registrar
Roundup Memorial Healthcare, Roundup, MT

Hi Fellow Registrars:

My name is Vicki Smith and I work at Roundup Memorial Healthcare in Roundup, Montana. Our facility is a Critical Access Hospital in rural Montana. I have been doing the tumor registry abstracting for our facility for 15+ years. I really enjoy the research aspect of abstracting. Since our facility is so small we generally do not do any major cancer diagnosing or treatment. If there is a suspicion of a patient having cancer they are referred to a larger facility in Billings for diagnosis and treatment. I have implemented the state transferring system of sending documentation to the Montana Tumor Registry. I have also received numerous Certificates of Excellence for timeliness in reporting the tumor abstracts, although this year it has been quite a challenge with the implementation of our new Electronic Medical Record Cerner and my reporting has not been timely, I am hoping to achieve that status again.

My husband and I have lived in Roundup for 23 years and have raised two wonderful children. We like to go camping and fishing in this wonderful Big Sky Country. In my spare time I like to crochet and make beaded jewelry.

MCTR Data for 2012 is 108.0% Complete

The North American Association for Central Cancer Registries (NAACCR) estimates that the MCTR is 108% complete for the 2012 diagnosis year.

What? How does that happen?! How can a database be 108% complete?

The NAACCR Method to Estimate Completeness Worksheet is used to estimate expected cases based on observed cancer incidence, death rates, and a comparison of standard rates of incidence and mortality in the U.S. It's complicated, but this method of estimation is standardized across all registries. Site-specific rates are calculated for White males and females and Black males and females.

For example: for White male esophageal cancer, the MCTR rate is 8.6/100,000 population. After the calculations are done using Montana incidence data, Montana mortality data, SEER incidence data, and U.S. mortality data, our "expected" incidence should be 6.7/100,000 population. We are slightly above our expected rate. This calculation is done for about 16 cancer sites to estimate our completeness. When we are "slightly" above the expected rate for many sites, it adds up to more than 100%.

We know that there are still some missing cases that we've never received— the bladder cancers that are treated in the urologists office and never reported. Well, as it turns out, we are slightly under our expected reporting for bladder cases. The MCTR rate for White male bladder cancers is 37.1/100,000 population. Our expected rate is 40.4/100,000 population.

Overall, it really is just an estimate, a way for the MCTR to look at specific sites to see where cases might be underreported and potentially implement reporting from the appropriate sources.

Data Use and Research: Data in Action: Address at DX

Source: NAACCR Narrative Spring 2015, Recinda Sherman, MPH, PhD, CTR (Abbreviated) For the full article go to http://newsmanager.commpartners.com/naaccr/issues/2015-04-23/15.html

Cancer registries are legislatively mandated to collect confidential data, including demographic data and tumor characteristics, to monitor cancer trends, aid in epidemiologic research, focus cancer control activities, and address public questions and concerns regarding cancer. An important element in this cancer surveillance system is the address at diagnosis fields.

The impetus for collecting address at diagnosis is that cancers and risks for cancers are not randomly disbursed across physical space. Health behaviors, positive ones like cancer screening and negative ones like smoking, vary by geography and influence cancer rates. Social factors, both mutable like community-based cancer control programs, and immutable like the distribution of a community by age or race, also vary by geography and impact cancer rates. Collecting address at diagnosis allows us to map these geographic differences to target cancer control efforts and inform epidemiologic research.

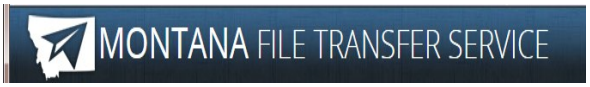
The need to collect the address at diagnosis is most obvious for cancer cluster evaluation and place-based research such as treatment or survival outcomes based on proximity to medical care. *Continued on next page*

Certificate of Excellence Recipients

The following facilities received a certificate for the 2015 First Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Yellowstone Dermatology	Billings
Montana Skin Ca & Dermatology	Bozeman
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Helena Dermatology	Helena
Associated Dermatology	Helena
Glacier Oncology	Kalispell
Hospitals:	
Billings Clinic	Billings
St. Vincent Healthcare	Billings
Bozeman Deaconess Hospital	Bozeman
St. James Hospital	Butte
Teton Medical Center	Choteau
Frances Mahon Deaconess Hospital	Glasgow
Benefis-Sletten Cancer Center	Great Falls
St. Peter's Hospital	Helena
Kalispell Regional Medical Center	Kalispell
Central Montana Hospital	Lewistown
Cabinet Peaks Medical Center	Libby
St. Patrick Hospital	Missoula
Ruby Valley Hospital	Sheridan
Broadwater Health Center	Townsend
Pathology:	
Yellowstone Path Institute	Billings
Northern Plains Pathology	Great Falls
St. Patrick Hospital Pathology	Missoula
Western Montana Clinic	Missoula

The File Transfer Service has a New Look



https://app.mt.gov/epass/Authn/selectIDP.html

The File Transfer Service has been updated with a new look. When you login, the webpage defaults to your Sent Files tab. You can also view your Received Files tab. A new tab on the page is User Preferences which allows you to change your settings for how often you want to be notified about how long your files will be available. This is very cool! You can also click the Instructions button to learn more about how the system works or use the Feedback button to provide your input about the FTS.

From both the Sent Files tab and the Received Files tab, you can Send a New File or Files. This process is visually different than the old system so here's a brief overview on how to send a file or multiple files:

1. Click on Send a New File(s) (blue button).
2. Under **Select Files to Upload**, browse for your file (Browse…) and click Upload (blue button); do the same process for additional files.
3. Each file that was uploaded should show in the box under the "name" title.
4. Click Continue (bottom blue button).
5. **Under Recipient Options**, click on State Employee or ePass Montana Customer.
6. **Under Recipients**, in the To: box type the e-mail address of the person(s) you are sending the file(s) to dlemons@mt.gov, ddean@mt.gov, paigejohnson@mt.gov for data submissions or vweedman@mt.gov for follow-up reports. Press the Enter key after *each* name. Or you can search for them and click the + sign next to the name. Unfortunately, the List of Previous Contacts is no longer available.
7. The name box turns green once the email address is typed in and you press enter.
8. In the Message box: type a message if desired.
9. Click Send (bottom right blue button).
10. You will get a **Sent Receipt** that indicates the Upload was a success, who the file was delivered to, and show your message.
11. When you click Continue, you will go back to the Sent Files tab.

If you read this newsletter, e-mail Debbi Lemons at dlemons@mt.gov, tell her that you read the newsletter, and you'll get a prize! Offer expires July 31, 2015!

Data Use and Research: Data in Action: Address at DX continued

There are barriers to collection of accurate address at diagnosis. One problem is a homeless patient. The street address of a homeless patient should be coded as the address of the facility diagnosing the patient. It is recommended practice to enter "homeless" into the supplemental address field so that they can be handled appropriately in research studies. And, addresses may be missing completely, although these are almost exclusively for historical cases. Missing addresses are coded "UNKNOWN" but a missing address is a rare event for an analytic case. And an address can have typographical errors.

But the largest the problem is the use of PO Box addresses instead of street addresses. Although a PO Box address can be useful in linkage studies, a PO Box does not represent the location where the patient lives or where area-based information was collected and can't be used in geospatial research. A PO Box address should only be coded as address at diagnosis as a last resort. Recommended practice is to enter the street address into the address at diagnosis field and the PO Box address into the supplemental address field.

The most effective improvements in collecting street address can be made at the hospital cancer registry level. Hospital registrars are closer to the source data. In some hospitals, registrars work with the billing department to determine the patients street address. Hospital registrars can use many of the same web-based resources available to central registries to search for an address. It is recommended practice to use external resources to correct typos and replace PO Box addresses with street address.

Epidemiologists rely on these fields to map data, focus resources, and evaluate etiologic relationships. Inaccurate address information has the potential to bias study results, exclude patients from potential study participation, decrease the utility of mapped cancer rates, decrease the match rate of linkage, and decrease the usability of our data in research.